



PROFESSIONAL ASSOCIATES

Notice of Independent Review Decision

DATE OF REVIEW: 03/10/08

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Three phase bone scan (78315), ther/proph/diagnostic injection IV push (90774), and nuclear medicine data proc (78890) - Upheld

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Board Certified in Anesthesiology
Fellowship Trained in Pain Management
Added Qualifications in Pain Medicine

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

Three phase bone scan (78315), ther/proph/diagnostic injection IV push (90774), and nuclear medicine data proc (78890)

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Evaluations with M.D. dated 03/16/06, 03/30/06, 04/04/06, 04/06/06, 04/21/06, 05/12/06, and 05/26/06

An MRI of the left shoulder interpreted by M.D. dated 04/17/06

A Functional Capacity Evaluation (FCE) with O.T.R. dated 05/24/06

Evaluations with M.D. dated 12/27/06, 01/17/07, 02/09/07, and 03/09/07

Evaluations with M.D. dated 01/23/07, 02/20/07, 03/09/07, 12/19/07, and 01/30/08

Preauthorization request forms dated 01/25/07 and 01/17/08

A Medical Record Review from M.D. dated 02/14/07

Evaluations with M.D. dated 02/22/07, 03/15/07, and 04/26/07

An MRI of the left knee interpreted by an unknown provider (no name or signature was available) dated 09/28/07

An evaluation with M.D. dated 12/19/07

Adverse Determination letters, according to the ODG, dated 01/18/08 and 02/01/08

The ODG Guidelines were not provided by the carrier or the URA

PATIENT CLINICAL HISTORY

On 03/16/06, Dr. recommended physical therapy, Motrin, Ultracet, and Ketoprofen cream. An MRI of the left shoulder interpreted by Dr. on 04/17/06 revealed mild tendinosis of the supraspinatus tendon and a small anterolateral subacromial spur. An FCE with Mr. on 05/24/06 revealed the patient would benefit from a work hardening program. On 05/26/06, Dr. recommended a work conditioning program. On 01/17/07, Dr. recommended physical therapy. On 01/25/07, wrote a preauthorization request form for a three phase bone scan. On 02/14/07, Dr. recommended only a few follow-up visits and a home exercise program, as well as over-the-counter medication. On 02/22/07, Dr. recommended an MRI of the thoracic spine, an evaluation with a chiropractor, and continued therapy. On 03/15/07, Dr. recommended physical therapy, a thoracic MRI, and a chronic pain management program. On 04/26/07, Dr. recommended an EMG/NCV study and a CT scan of the thoracic spine. An MRI of the left knee interpreted by an unknown provider on 09/28/07 revealed two discrete osteochondral lesions affecting the medial femoral condyle. On 12/19/07, Dr. recommended a left lumbar sympathetic block, Lyrica, Hydrocodone, Motrin, and a TENS unit. On 12/19/07, Dr. felt the patient was ready for Maximum Medical Improvement (MMI). On 01/18/08 and 02/01/08, wrote letters of non-authorization for a bone scan.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

There is clearly very significant discrepancy between the examination documented by Dr. on 12/19/07 and that documented immediately thereafter by Dr. on the same date. For example, Dr. points out that the patient jumped off the table with palpation and reacts severely to any palpation, yet documented that he was able to perform a Lachman's test and anterior drawer test, both of which were negative. These tests involve grasping of the knee and moving it anteriorly and posteriorly, a maneuver that would certainly cause intolerable pain in a patient with valid hypersensitivity and allodynia, as alleged by Dr. in his examination on that same date. Dr. also documented the patient having 110 degree range of motion in flexion, again significantly different than that documented later that day by Dr.. Finally, Dr. documented information from the physical therapist indicating that the patient apparently had no problem ambulating when she was not being observed, but immediately upon being in an observed status by the physical therapist, she demonstrated significant pain and limited function. Such evidence of functional overlay is more indicative of malingering and factitious disorder than of any valid clinical condition, such as complex regional pain syndrome (CRPS).

A triple phase bone scan can be a useful diagnostic tool in a patient who does not demonstrate sufficient physical examination evidence to support a diagnosis of CRPS, yet for whom there is a significantly high index of suspicion for that diagnosis. In and of itself, however, a triple phase bone scan is not diagnostic of CRPS or RSD. Additionally, a triple phase bone scan is not medically reasonable or necessary to, as Dr. alleges, "identify the demineralization of the left lower extremity," as such an identification would in no way alter the clinical course or options available for or necessary to treat this patient's ongoing left knee pain. Therefore, based upon the records provided for my review, which do not document that this patient has had a lumbar sympathetic block to verify the sympathetic nature of her pain complaint and, therefore, lend credibility to a diagnosis of CRPS, there is no medical reason or necessity for the requested triple phase bone scan. It would not provide a definite diagnosis nor would it alter the clinical course of this patient or provide treatment options not already available. ODG Treatment Guidelines similarly do not support or recommend a triple phase bone scan for diagnosis or evaluation of RSD/CRPS. It is generally considered a non-specific test, not necessary in a patient for whom a definitive diagnosis of RSD/CRPS is not present.

Therefore, for all the reasons cited above, the request for a three phase bone scan (78315), ther/proph/diagnostic injection IV push (90774), and nuclear medicine data proc (78890) is not medically reasonable or necessary and the previous recommendations made by two separate physician advisers for non-authorization are both upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE AND KNOWLEDGE BASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)